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SIPDIS
AIDAC

AFR/SA FOR ELOKEN, LDOBBINS, BHIRSCH, JHARMON
OFDA/W FOR KLUU, ACONVERY, LPOWERS, TDENYSENKO
FFP/W FOR JBORNS, ASINK, LPETERSEN
PRETORIA FOR HHALE, PDISKIN, SMCNIVEN
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SUBJECT: ZIMBABWE CHOLERA USAID DART SITUATION REPORT #1

REF: A) HARARE 1119

HARARE 00001129 001.2 OF 003

SUMMARY

¶1. As of December 15, the U.N. Office for the Coordination of Humanitarian Affairs (OCHA) reported a total of 18,413 cholera cases in Zimbabwe since the outbreak began in August, with 978 deaths and a case fatality rate (CFR) of 5.3 percent. Humanitarian organizations consider a CFR over 1 percent as the emergency threshold for cholera. As of December 15, the highest cholera caseloads by district were in Harare, Beitbridge, and Mudzi districts. In response to the ongoing cholera outbreak, USAID activated a Disaster Assistance Response Team (USAID/DART) on December 10. On December 11, the USAID Administrator pledged USD 6.2 million for cholera mitigation and response activities.

¶2. On December 15, the USAID/DART health advisor met with the U.N. World Health Organization (WHO) senior epidemiologist from Geneva, the U.N. health and water, sanitation, and hygiene (WASH) cluster leads, and the U.N. Children's Fund (UNICEF) emergency health coordinator from New York regarding the status of the cholera command and control center, as well as strengthening coordination between the health and WASH clusters. On December 13, the USAID/DART health advisor and U.S. Centers for Disease Control and Prevention (CDC) WASH advisor conducted an assessment of a recent cholera outbreak in Chegutu town with the International Organization for Migration (IOM). The health and WASH advisors met with local health officials, community members, and attended the initial coordination meeting of responding humanitarian organizations. End Summary.

HUMANITARIAN SITUATION

¶3. As of December 15, OCHA reported a total of 18,413 cholera cases in nine of the 10 provinces in Zimbabwe since the outbreak began in August, with 978 deaths and a CFR of 5.3 percent. Humanitarian organizations consider a CFR over 1 percent as the emergency threshold for cholera. As of December 15, the highest cholera caseloads by district were in Harare, Beitbridge, and Mudzi districts. The most recent large outbreak was reported in Chegutu District, southwest of Harare.

¶4. The Government of Zimbabwe (GOZ) Ministry of Health and Child Welfare (MOHCW) and WHO reported on a December 10 to 12 assessment in Mudzi District in northeast Zimbabwe, where the second cholera outbreak of the year began on October 6. As of December 12, the MOHCW had recorded 1,526 cholera cases, with 39 deaths in health centers, 49 deaths in the community, and a CFR of 2.56 percent. As of December 15, Mudzi had the third highest total number of cholera cases reported at the district level. On December 9, the USAID Office of U.S. Foreign Disaster Assistance (USAID/OFDA) Zimbabwe humanitarian coordinator and the CDC WASH advisor conducted an assessment in Mudzi District.

¶5. The cholera outbreak in Zimbabwe has spread to border areas of neighboring countries, particularly affecting South Africa as Zimbabweans cross the border to seek medical treatment. As of December 12, South Africa had registered 859 cholera cases, including 731 in Limpopo Province, with 11 fatalities, according to the U.N. health cluster. The CFR was reported at 1.2 percent.

¶6. On December 11, USAID/OFDA's principal regional advisor based in Pretoria, South Africa, traveled to Musina to assess the situation. The principal regional advisor reported that outbreak was currently under control but the caseload could spike with seasonal migration, and indicated that additional hygiene promotion and distribution of hygiene supplies may be needed. Save the Children and IOM are

currently assisting local South African health authorities to respond to the outbreak.

USG RESPONSE AND DEPLOYMENT OF USAID/DART

¶7. On December 5, a health advisor from USAID/OFDA and a WASH advisor from CDC arrived in Harare to assess the cholera outbreak. On December 10, to augment ongoing response efforts, USAID activated a USAID/DART.

¶8. On December 11, the USAID Administrator pledged USD 6.2 million for the cholera response. The funding was in addition to the USD 4.6 million provided by USAID/OFDA in FY 2008 and to date in FY 2009 for WASH interventions. On December 15, the Charge d'Affaires a.i. declared a disaster due to the continuing cholera outbreak (REFTEL). In FY 2008 and to date in FY 2009, USAID has provided more than USD 220 million in emergency assistance to Zimbabwe, including nearly 180,000 metric tons of P.L. 480 Title II emergency food assistance.

HUMANITARIAN COORDINATION

¶9. On December 15, the USAID/DART health advisor met with the WHO senior epidemiologist from Geneva, the U.N. health and WASH cluster leads, and the UNICEF emergency health coordinator from New York regarding the status of the cholera command and control center, as well as strengthening coordination between the health and WASH clusters. The meeting helped to define the roles of the clusters in the context of the control center. WHO updated the U.N. health cluster on the control center status on December 16.

¶10. The control center is a technical coordination unit to monitor, guide, and evaluate interventions related to cholera outbreak response for disease surveillance, case management, WASH, social mobilization, and logistics. The center will provide guidance and strategies for the implementation of control measures and provide

recommendations to the clusters, including the logistics cluster, as well as monitoring implementation of the measures. The WHO senior epidemiologist indicated that if successful, the center could be used as a model for future outbreaks globally.

¶11. WHO is in the process of mobilizing staff for the center and selecting a trained health cluster coordinator from the global health cluster roster. Donors are advocating for an experienced coordinator with strong leadership skills to ensure that there is good guidance and response. The staff for the center will come from a Global Outbreak Alert and Response Network alert and will include staff from the International Centre for Diarrhoeal Disease Research, Bangladesh for case management.

HEALTH

¶12. On December 8, local authorities set up a treatment center in Epworth, an informal settlement approximately 12 km southeast of Harare, with a large population and little public infrastructure. The treatment center lacks water, electricity, and the fuel needed for transportation to conduct disease surveillance and community mobilization. To date, the number of cholera cases remains low, but WHO highlighted Epworth as an area where prevention and social mobilization activities are needed to prevent a large outbreak.

¶13. On December 15, the non-governmental organization World Vision reported delivering essential drugs valued at USD 7 million. The supplies include both drugs for cholera treatment and for general health care.

ASSESSMENT IN CHEGUTU DISTRICT

¶14. On December 9, local health officials in Chegutu observed a large increase in cholera cases and deaths in the town. The alert did not go out to authorities in Harare until December 10, and was not received by WHO and other humanitarian organizations until December 12. The lack of information led to a delayed response and resulted in a high CFR at the peak of the outbreak as the number of patients overwhelmed the local health system. On December 12, the local organization Celebration Health responded with medical supplies and a team of doctors and nurses. As of December 15, OCHA reported 378 cholera cases and 121 deaths, with a CFR of 32 percent in Chegutu town. In the remainder of Chegutu District, a much lower CFR of 3.3 percent was recorded, with 368 cases resulting in 12 deaths.

¶15. On December 13, the USAID/DART health advisor and CDC WASH advisor conducted an assessment of the situation in Chegutu town with IOM. During the USAID/DART visit on December 13, other agencies, including Medecins Sans Frontieres (MSF), UNICEF, WHO, Concern and IOM were present.

¶16. The USAID/DART health and WASH advisors noted that the outbreak was likely due to a combination of unprotected shallow wells and cross-contamination of the town sewage and water lines. The town public health engineer said that sewage contamination of the wells may also be the cause or contributing factor to the outbreak. There are no boreholes or other sources of safe water in the two most affected wards of Chegutu town.

¶17. Discussions with the community revealed a good understanding that the contaminated water supply has made the community sick and participants were very interested in methods of improving the water system. The community members also had a good understanding of how to use sugar and salt for oral rehydration. Some of the people interviewed were not going to the treatment center because the facilities were too crowded and the individuals thought they would not receive care.

¶18. During the USAID/DART assessment, an initial coordination meeting was held on the grounds of the treatment center, with all

responding agencies and local health officials present. Two teams were created, one to focus on the treatment center and the other to work with communities. Concern, IOM, and UNICEF agreed to take the lead on community mobilization, distribution of soap, aquatabs, and water containers, and provision of safe water. UNICEF will provide four to five 10,000 liter water bladders and arrange for water tankering from a nearby borehole, beginning December 14. The town engineer shut off water to the two most affected wards of Chegutu city. Concern will organize distribution of water containers, soap, and water treatment tablets. Agencies with local counterparts will mobilize community workers and chuch leaders to deliver hygiene promotion and cholra awareness messages.

¶19. The district health officials, MSF, WHO, and Celebration Health will coordinate the treatment center and case management. Celebration Health has provided doctors and nurses, while UNICEF, MSF, IOM and WHO have been supplying medical commodities. WHO will continue to monitor the situation in coordination with local health authorities.

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